

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No.

33699

Registrar's No.

4374

Registration District No.

Primary Registration District No.

1002

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1637 Lawn
Outpatient-K.C. General Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution Not hospital pt.
 In this community 24 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME Fred Baker

3. (b) If veteran, name war no 3. (c) Social Security No. 496-093323

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Ruey Esther Baker 6. (c) Age of husband or wife if alive 38 years
 7. Birth date of deceased Apr 28 - 1886
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
57 5 15 hr: min.

9. Birthplace Kansas (City, town, or county) (State or foreign country)

10. Usual occupation Painter & Decorator

11. Industry or business
 12. Name Geo. C. Baker
 13. Birthplace Lowell (City, town, or county) (State or foreign country)
 14. Maiden name Anna Ferris
 15. Birthplace no record (City, town, or county) (State or foreign country)

16. (a) Informant Ruey Esther Baker

(b) Address 1637 Lawn

17. (a) Burial (b) Date thereof Oct-16-43
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Mr. C.R. Foster

(b) Address 918 Brooklyn

19. (a) 10-15-43 (b) J.E. Brown
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
 (c) City or town Kansas City
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1637 Lawn Avenue
 (If rural, give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 13 year 1943 hour 12 minute 30 P.M.

21. I hereby certify that I attended the deceased from September 1942 to 10-12-1943, 19...
 that I last saw him alive on 10-12-43, 19...
 and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic heart disease with cardiac decompensation

Due to 2

Due to ASC

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....
 (b) Date of occurrence.....
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work (Specify type of place) (a) Means of injury

23. Signature Ruey R. Thorn (M. D. or other) Fed. Dir. K.C. Gen. Hospital

Address Date signed 10-14-43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Theron P. Redmon

Licensed Embalmer No. 2737

P. O. Address H. P. me

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.